UNIFORM SUSPECTED INSURANCE FRAUD REPORTING FORM

State of Arkansas
Insurance Fraud Investigation Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

For State Use Only
Case No. Status FYI

Reporting Person:	Insurance Company:	NAIC#
Mailing address:	Phone number: Fax number: E-mail address:	
Detailed synopsis. For additional space use attached page (page 4) if necessary.		
Date of Loss / Injury: Address of Loss / Injury: (City) (State) (Zip)	Dates of Service: to Description of Service:	
Claim #	Policy #	

Reserve Amount $	Amount Paid $	Date Paid	Procedure Code #'s: ☐ CPT ☐ CDT	Insurance Type ☐ PC ☐ WC ☐ HC ☐ Auto ☐ Life ☐ Disability
Loss Amount $	Settlement Amt. $	Date Paid	Civil Litigation Pending: ☐ Yes ☐ No	

Subject Information

Type:	Name (Last / Business):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):	Address Type: ☐ Res. ☐ Bus. ☐ Maildrop ☐ Other	Fed. TIN ☐ EIN ☐ Number:	Sex: M ☐ F ☐			
City:	State:	Zip:	County:	Telephone No.:	Phone Type: ☐ home ☐ cell ☐ bus.	
Driver's License #:	State:	VIN:	Telephone No.:	Phone Type: ☐ home ☐ cell ☐ bus.		
Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:		
Employer:	Address & Phone #:	Occupation:				
Additional Party Involved ☐ **See Additional Party Involved/AKA Information** AKA Information: ☐	Comments:					

Case Details (check all that apply)

SIU Investigation Completed ☐ Yes ☐ No Date Completed:

Is there any reason to believe that this incident is related to other suspected fraudulent activity? ☐ Yes ☐ No

☐ Statements (Witness / Insured / Subject)	☐ EUO / Deposition	☐ Law Enforcement / Other Agency Reports
☐ Sworn ☐ Recorded	☐ Copies of Receipts	☐ Claim History Extracts
☐ Proof of Loss	☐ Expert Reports	☐ IME Reports
☐ Continuance of Disability Forms	☐ Videos / Photos	☐ Investigative Reports
☐ Medical Records	☐ Claim Information	☐ External Database results
☐ Other	☐ Other	☐ Other

Identify Other Agency You Have Contacted Regarding This Referral

Agency Type: ☐ Other State Fraud Bureau ☐ Law Enforcement ☐ Other Insurance Company ☐ Regulatory Agency ☐ Other

Agency: _____ Contact Person: _____
(Address) _____ (City) _____ (State) _____ (Zip) _____
Telephone (____) _____ Fax (____) _____ Case/Claim No._____

Suspected Fraud Types (check all that apply)

- ☐ Arson
  - ☐ home ☐ vehicle ☐ business
- ☐ Fictitious loss ☐ damages ☐
- ☐ Fictitious theft
  - ☐ vehicle ☐ property
- ☐ Inflated inventory
- ☐ Inflated loss ☐ damages ☐
- ☐ Inflated theft
  - ☐ vehicle ☐ property
- ☐ Double-dipping
- ☐ Exaggerated injuries
- ☐ Injuries not related to work
- ☐ Malingerers
- ☐ Misappropriated vehicle salvage
- ☐ Premium avoidance
- ☐ Prior injuries
- ☐ Slip and fall
- ☐ Staged injury / accident at work
- ☐ Staged collisions
- ☐ Paper accidents
- ☐ Other _____
- ☐ Agent fraud
- ☐ Application fraud
- ☐ Billing for services/products not provided
- ☐ Failure to disclose multiple insurance companies
- ☐ False claims
- ☐ Illegal solicitation (cappers)
- ☐ Issued fraudulent insurance policies, certificates, binders, ID cards
- ☐ Misrepresentation of services / products provided
- ☐ Kickbacks/bribery
- ☐ Money laundering
- ☐ Multiple claims
- ☐ Possession/sold fraudulent insurance policies, certificates, binders, ID cards
- ☐ Questioned documents
  - ☐ altered ☐ forged ☐ falsified ☐ duplicated
- ☐ Received compensation for referral to health care provider or attorney
- ☐ Ring / organized activity type
- ☐ Duplicate billing for same service
- ☐ Forged prescriptions
- ☐ Fraudulent death claims
- ☐ Over-utilization of services
- ☐ Prescription abuse / doctor shopping
- ☐ Prescriptions issued for non-medical purposes
- ☐ Unbundling
- ☐ Upcoding
- ☐ Misrepresented non-covered services as covered
- ☐ Changing dates of service, CPT/CDT/diagnostic codes
- ☐ Charges inconsistent with services provided
- ☐ Products billed are inconsistent with the products
- ☐ Using unqualified/unlicensed persons to perform billable services
- ☐ Other _____

Subject / Additional Party Types

CL	Claimant
IN	Insured
WT	Witness
LC	Lawyer for Claimant
LI	Lawyer for Insured
INS	Insurer
SI	Self-Insured
IY	Insurance Company Employee
IB	Agent/Broker
IS	Adjuster
IR	Appraiser
BS	Body Shop
SY	Salvage Yard Owner / Employee
TY	Tow Yard Owner / Employee
MD	Medical Doctor
DO	Doctor of Osteopathic Medicine
DEN	Dentist
PH	Pharmacist
CHI	Chiropractor
NP	Nurse Practitioner
LPN	Licensed Practical Nurse
PT	Physical Therapist
PA	Physician's Assistant
OP	Optometrist
PO	Podiatrist
RD	Radiologist
MT	Massage Therapist
AMB	Ambulance Service Employee
DME	DME Supplier
HHA	Home Health Agency
MR	Laboratory
MH	Medical Clinic/Hospital
MZ	Office Administrator
BS	Billing Services
TPA	Third Party Administrator
FP	False Provider
UP	Unlicensed Provider
MN	Other Medical Personnel
MS	Medical Specialist
_____	
DS	Dental Specialist
_____	
NS	Nurse Specialist
_____	
OT	Other
_____	

Additional Party Involved / AKA Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):		Address Type: ☐Res. ☐ Bus. ☐ Maildrop ☐ Other		Fed. TIN☐ EIN☐ Number:		Sex: M ☐ F ☐
City:	State:	Zip:	County:	Telephone No.:		Phone Type: ☐ home☐ cell☐ bus.
Driver's License #:	State:	VIN:		Telephone No.:		Phone Type: ☐ home☐ cell☐ bus.
Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:		
Employer:	Address & Phone #:			Occupation:		
Involvement in referral:						

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Additional Detailed Synopsis page:

Submit Form